



Comprehensive ESRD Care (CEC) Model Telehealth - Implementation

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PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) and participating in the Comprehensive ESRD Care (CEC) Model for telehealth services provided to Medicare End-Stage Renal Disease (ESRD) beneficiaries associated with the CEC Model.

PROVIDER ACTION NEEDED

Change Request (CR) 10314 details the CEC Model telehealth program and how it will be implemented. Make sure your billing staffs are aware of this initiative.

BACKGROUND

Section 1115A) of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act (ACA) (42 USC 1315a) authorizes the Center for Medicare and Medicaid Innovation (CMMI) to test innovate health care payment and service-delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

The CEC Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. Through the CEC Model, the Centers for Medicare & Medicaid Services (CMS) will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The Model builds on Accountable Care Organization (ACO) experience from the Pioneer ACO Model, Next Generation ACO Model, and the Medicare Shared Savings Program to test ACOs for ESRD beneficiaries.

More than 600,000 Americans have ESRD and require life-sustaining dialysis treatments several times per week. Many beneficiaries with ESRD suffer from poorer health outcomes, often the result of underlying disease complications and multiple co-morbidities. These can lead to high rates of hospital admission and readmissions, as well as a mortality rate that is higher than that of the general Medicare population.

According to United States Renal Data System, in 2014, ESRD beneficiaries comprised less than 1 percent of the Medicare population, but accounted for an estimated 7.2 percent of total Medicare Fee-For-Service (FFS) spending, totaling more than \$32.8 billion.

Because of their complex health needs, beneficiaries often require visits to multiple providers and follow multiple care plans, all of which can be challenging for beneficiaries if care is not coordinated. The CEC Model seeks to create incentives to enhance care coordination and to create a person-centered, coordinated care experience, and to ultimately improve health outcomes for this population.

In the CEC Model, dialysis clinics, nephrologists and other providers collaborate to create an ESRD Seamless Care Organization (ESCO) to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries' health needs, both in and outside of the dialysis clinic.

The CEC Model includes separate financial arrangements for larger and smaller dialysis organizations. Large Dialysis Organizations (LDOs), defined as having 200 or more dialysis facilities, will be eligible to receive shared savings payments. These LDOs will also be liable for shared losses and will have higher overall levels of risk compared with their smaller counterparts.

Non-Large Dialysis Organizations (Non-LDOs) include chains with fewer than 200 dialysis facilities, independent dialysis facilities, and hospital-based dialysis facilities. Non-LDOs will have the option of participating in a one-sided track where they will be able to receive shared savings payments, but will not be liable for payment of shared losses, or participating in a track with higher risk and the potential for shared losses. The one-sided track is offered in recognition of the Non-LDOs more limited resources.

The CEC Model began on October 1, 2015, and will run until December 31, 2020. The CEC Model conducted a solicitation in 2016 to add more ESCOs for Performance Year 2 of the model, beginning on January 1, 2017. The CEC Model has no current plans for another round of solicitations.

The CEC Model LDO payment track and Non-LDO two-sided payment track are considered Advance Payment Models (APMs) regarding the Quality Payment Program.

The CEC Model will implement design elements with implications for the FFS system for its third

performance year that includes benefit enhancements to give ACOs the tools to direct care and engage beneficiaries in their own care. The model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits. The model's quality requirements are similar to Shared Savings Program (SSP) and Pioneer, modified as needed to take into account unique aspects of dialysis care, in keeping with the agencies initiatives to unify and streamline quality measurement and requirements.

Telehealth Waiver

In order to emphasize high-value services and support the ability of ESCOs to manage the care of beneficiaries, CMS plans to design policies and use the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the CEC Model.

CMS will make available to qualified ESCOs a waiver of the originating site requirement for services provided via telehealth. This benefit enhancement will allow beneficiaries to receive qualified telehealth services in non-rural locations and locations that are not specified by statute, such as homes and dialysis facilities. The waiver will apply only to eligible aligned beneficiaries receiving services from ESCO providers.

An aligned beneficiary will be eligible to receive telehealth services through this waiver if the services are otherwise qualified with respect to:

- 1) The service provided, as designated by Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, and
- 2) The remote site.

MACs will apply claims processing edit logic, audit, medical review, Medicare Secondary Payor, and fraud and abuse activities, appeals and overpayment processes for CEC claims in the same manner as normal FFS claims.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under Section 1834(m)(4)(F) of the Act, and subsequent additional services specified through regulation with the exception that claims **will not** be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or Skilled Nursing Facilities (SNFs) - HCPCS codes G0406-G0408.
- Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days - CPT codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days - CPT codes 99307-99310.
- Telehealth consultations, emergency department or initial inpatient - HCPCS codes G0425-G0427.

- Telehealth Consultation, Critical Care, initial - HCPCS code G0508.
- Telehealth Consultation, Critical Care, subsequent - HCPCS code G0509.
- Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service - CPT codes 99356-99357.

MACs will be ready to process Part B CEC claims for dates of service on or after October 1, 2018. MACs will process CEC telehealth claims (Place of Service (POS) 02) when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the Date of Service (DOS) on the claims and contains the demo code 85 and one of the following CPT or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

For Part A CEC claims when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the Date of Service (DOS) on the claims submitted on Type of Bill (TOB) 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X, or 85X and contains the demo code 85 and one of the following CPT or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

MACs will not process as CEC telehealth claims that contain the following codes. Claims that contain these codes can be processed following existing claims processing logic:

- HCPCS codes G0406 – G0408.
- CPT codes 99231 – 99233.
- CPT codes 99307 – 99310.
- HCPCS codes G0425-G0427
- HCPCS code G0508
- HCPCS code G0509
- CPT codes 99356-99357

MACs will treat CEC payments the same as Medicare patients for cost reporting purposes.

Providers submitting electronic 837 claims should enter DEMO 85 in the REF segment 2300 Loop Demonstration Project Identifiers and providers will include Qualifier P4. Providers submitting a paper claim should enter demo 85 in the treatment authorization field.

Providers should be aware that MACs will return claims if you append demo code 85, and:

- You are not on the CEC participant provider list with a telehealth record type; or
- DOS “from date” is prior to your telehealth effective date, or
- DOS “from date” is after your telehealth termination date, or
- The DOS “from date” is prior to the beneficiary’s effective date; or
- The DOS “from date” is after the beneficiary’s termination date, or
- The DOS “from date” is more than 90 days after the beneficiary’s termination date; or
- The beneficiary was not aligned to the same ESCO with which you are participating, as identified by ESCO ID; or
- The claim is for Part A and the TOB is other than 12X, 13X, 22X, 23X, 71X, 72X, 76X, 77X, and 85X,
- Other, non-telehealth services are billed on the same claim. In these cases, none of the services on the claim are processed.

In returning Part B claims, your MAC will use the following messaging:

- Claims Adjustment Reason Code (CARC) 16: (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication) and
- Remittance Advice Remark Code (RARC) N763 (The demonstration code is not appropriate for this claim; resubmit without a demonstration code.)
- Group Code: CO (Contractual Obligation)

For Part A claims, your MAC will just return the claim to the provider (RTP).

ADDITIONAL INFORMATION

The official instruction, CR10314, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R198DEMO.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
June 28, 2018	The article was revised to reflect a revised CR10314 issued on June 27. In the article, the CR release date, transmittal number, and the Web address of the CR are revised. All other information remains the same.
April 27, 2018	Initial article released.

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